



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

APRIL 2019 HIGHLIGHTS

Congressional Testimony

Deputy Assistant Inspector General for Audits and Evaluations Testifies before the House Veterans' Affairs' Subcommittee on Technology Modernization

Mr. Brent Arronte, Deputy Assistant Inspector General for Audits and Evaluations, [testified](#) at a hearing before the House Committee on Veterans' Affairs' Subcommittee on Technology Modernization on April 2, 2019, regarding challenges facing VA's Office of Information and Technology. Mr. Arronte discussed VA's information security program and recommendations made by the Office of Inspector General (OIG) to address longstanding issues related to security, project management, and system development. He was accompanied by Mr. Michael Bowman, Director of the OIG's Information Technology and Security Audits Division.

Criminal Investigations Involving Health Care

Veteran Charged in Connection with Shooting at West Palm Beach, Florida, VA Medical Center

An investigation conducted by the VA OIG and the Federal Bureau of Investigation (FBI) resulted in charges that a veteran inflicted non-life-threatening injuries on two VA employees by firing a handgun inside the West Palm Beach, Florida, VA Medical Center. While being processed in the facility's emergency room on a psychiatric hold, the defendant opened fire on VA emergency room staff after becoming agitated. Two VA physicians and a veteran subdued the defendant until VA police officers arrived at the scene. The defendant is a convicted felon who was legally prohibited from possessing firearms or ammunition.

Former Providence, Rhode Island, VA Medical Center Intensive Care Unit Nurse Sentenced for Drug Tampering

A former Providence, Rhode Island, VA Medical Center Intensive Care Unit nurse was sentenced to 24 months' incarceration and 24 months' probation after previously pleading guilty to tampering with pre-packaged fentanyl and hydromorphone syringes. A VA OIG, VA Police Service, and Food and Drug Administration investigation revealed the defendant would withdraw the narcotic, inject saline back into the carpule (the device used for administering injectable fluid), and put the tampered drug back in the automated medication dispensing machine for distribution to patients.

Former Shreveport, Louisiana, VA Medical Center Pharmacist Indicted for Drug Diversion

A VA OIG and Drug Enforcement Administration (DEA) investigation resulted in charges alleging that the defendant diverted more than 200 controlled substances, including hydrocodone and morphine, from mail order prescription packages. The packages were inside the medical center outpatient pharmacy vault and were intended for veterans living in the local area. In addition, more than 1,600 noncontrolled

substances issued to different veterans were seized from the defendant's office. As part of the criminal indictment, the defendant was required to surrender her Louisiana pharmacist license and DEA number.

Veteran Arrested for Making Threats to Seattle, Washington, VA Medical Center

A VA OIG investigation resulted in the arrest of a veteran on charges alleging that he made threats towards the Seattle, Washington, VA Medical Center and the facility's personnel. During the course of this investigation, the OIG obtained an Extreme Risk Protection Order (ERPO) directed to the defendant. The ERPO required the defendant to surrender all firearms and restricted him from further possessing any firearms.

Criminal Investigations Involving Benefits

Veteran Sentenced for Compensation Benefits Fraud Scheme

A veteran was sentenced to 12 months' imprisonment and ordered to pay approximately \$1.3 million in restitution to the VA. A VA OIG investigation revealed that since 1969, the veteran lied to the VA in order to obtain a 100-percent service-connected disability rating for total blindness despite being able to drive a vehicle, maintain a Colorado driver's license, and ambulate without the assistance of walking aids.

Former VA Employee Pled Guilty for Role in Bribery Scheme

A former VA Specially Adapted Housing (SAH) grant agent pled guilty to conspiracy to commit bribery. A VA OIG investigation revealed that while the defendant was a VA employee, he received over \$20,000 in kickbacks from a business partner in exchange for directing approximately \$1 million in SAH grants for veterans' homes to his partner's company.

Former VA Fiduciary Indicted for Theft Scheme

A former VA-appointed fiduciary was indicted for theft of government funds. A VA OIG investigation resulted in charges alleging that the defendant stole more than \$100,000 in funds that were intended for her veteran father.

Criminal Investigations Involving Other Matters

Individual Sentenced for Role in Service-Disabled Veteran-Owned Small Business Fraud Scheme

A defendant was sentenced to 51 months' imprisonment and 3 years' supervised release after pleading guilty to wire fraud. A VA OIG, Defense Criminal Investigative Service (DCIS), Small Business Administration (SBA) OIG, Air Force Office of Special Investigations, Army Criminal Investigations Division, Department of Energy OIG, and Department of Agriculture OIG investigation revealed that more than \$350 million dollars in construction contracts were fraudulently obtained after several subjects conspired in creating companies for the sole purpose of obtaining set-aside government contracts. The subjects provided false qualifying information to VA and the SBA by concealing that the

companies were not controlled by veterans, service-disabled veterans, minorities, or women. Eleven associated companies and five defendants were suspended and subsequently debarred from obtaining future government contracts until March 2021. Additional business associates, including a service-disabled veteran, were previously sentenced.

Individual Pled Guilty for Role in Service-Disabled Veteran-Owned Small Business Fraud Scheme

A nonveteran business owner pled guilty to wire fraud. A VA OIG and FBI investigation revealed the defendant devised a “rent-a-vet” scheme to fraudulently obtain six VA construction projects throughout Ohio and Michigan. Numerous legitimate service-disabled veteran-owned small businesses were passed over as a result of the scheme. The largest contract involved the construction of an outpatient pharmacy in Cleveland, Ohio. The construction was delayed by the defendant’s company for at least six months and ultimately completed by another company. The loss to VA is approximately \$11.9 million.

Pharmaceutical Company Agrees to Settle False Claims Act Allegations

A VA OIG, Department of Health and Human Services (HHS) OIG, and FBI investigation resulted in a pharmaceutical company entering into a civil settlement agreement to pay \$52.6 million to the federal government. Of this amount, VA will receive approximately \$600,000. This agreement resolved allegations that the defendant violated the False Claims Act by illegally making copayments for Medicare and Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) patients through independent charitable foundations. The anti-kickback statute prohibits pharmaceutical companies from offering or paying, directly or indirectly, copayments to induce patients to purchase the companies’ drugs. Whenever a Medicare or CHAMPVA beneficiary obtains a prescription drug covered by the respective government program, the beneficiary may be required to make a partial payment that may take the form of a copayment, coinsurance, or deductible. This investigation determined that VA spent approximately \$3.2 million in purchases for one of the pharmaceutical company’s drugs.

Three Individuals Pled Guilty for Compound Pharmacy Scheme

Three owners/controllers of multiple pharmacies pled guilty to conspiring and engaging in a scheme to defraud the federal government and private healthcare insurance companies for more than \$200 million across multiple states. A VA OIG, Internal Revenue Service Criminal Investigation (IRS-CI), Mississippi Bureau of Narcotics, Department of Labor OIG, U.S. Postal Inspection Service, HHS OIG, DCIS, and FBI investigation revealed that the defendants fraudulently formulated, marketed, prescribed, and billed for compound medications produced and dispensed by pharmacies in south Mississippi. CHAMPVA paid fraudulent claims for compound medications to these pharmacies, which totaled approximately \$2.4 million.

Home Healthcare Company Owner Pled Guilty in Fraud Scheme

A home healthcare company owner who provided care to veterans as part of VA's Purchased Care program pled guilty to destruction, alteration, or falsification of records as well as healthcare fraud for fraudulently billing VA and Medicare. A VA OIG, FBI, and HHS OIG investigation revealed the defendant and other employees submitted altered therapy notes documenting home healthcare services to VA patients that were never provided by the company but were subsequently paid for by VA. The loss to VA is approximately \$868,000.

Defendant Agrees to Settle Fraud Allegations

A defendant entered into a settlement agreement with the United States pertaining to his role as a prime vendor on a VA contract. A VA OIG investigation revealed the defendant created fraudulent, improper, and exaggerated travel expenses while working on the VA contract. The defendant agreed to pay \$750,000, of which VA will receive \$630,000.

Five Individuals Arrested for Kickback Scheme

Five individuals were arrested for their role in a nationwide healthcare fraud scheme involving durable medical equipment companies, telemedicine doctors, and telemarketers. The defendants, who are owners and operators of telemarketing and durable medical equipment companies, are alleged to have violated anti-kickback and money laundering statutes. A VA OIG, FBI, IRS-CI, and HHS OIG investigation resulted in charges alleging that telemarketers pushed durable medical equipment to patients and used telemedicine doctors to certify medical necessity. The telemedicine doctors did not have a relationship with the patients, and the telemarketers sold the completed orders to the durable medical equipment companies. Many of the targeted companies identified in the scheme requested disbursements from the CHAMPVA program. The loss to VA is approximately \$330,000.

Healthcare Inspections

Review of Delays in Clinical Consult Processing at VA Boston Healthcare System, Massachusetts

The OIG reviewed a sample of the VA Boston Healthcare System's discontinued consults and determined that none were processed inappropriately. The OIG verified that facility leaders and managers monitored and analyzed consult data, communicated with service leaders about identified concerns, implemented clinical and administrative processes for performance improvement, and monitored the results. Veteran Integrated Service Network (VISN) leaders provided oversight for tracking access to care, managing consults, and other performance measures for the facility. They also conducted monthly management meetings with facility leaders to review access to care and consult processing concerns. The facility provided monthly reports on access to care and consult processing to the VISN for tracking. The OIG concluded that facility leaders were actively engaged and had effective performance improvement and consult management processes in place. Therefore, the OIG made no recommendations.

Quality and Coordination of a Patient's Care at the VA Eastern Colorado Health Care System in Denver, Colorado

This healthcare inspection reviewed a complainant's allegations and substantiated that care providers at the VA Eastern Colorado Health Care System failed to complete a patient's evaluation, including medication reconciliation. Incomplete evaluations may have contributed to the patient's declining health and hindered care. Providers also failed to appropriately treat the patient's underlying condition, recognize signs of illness, and identify an infection source. These failures may have contributed to the patient's death. Providers discussed discharge and care options with the competent patient but may not have discussed care with the patient's family. Providers also did not communicate care options to mitigate the patient's suffering. In addition, the OIG found that podiatry clinic scheduling was inconsistent, wound care clinic consults were incomplete, geriatric care coordination was deficient and likely contributed to worsening patient wounds, and podiatry resident supervision was not documented as required. The OIG made eight recommendations regarding medication reconciliation, provider education, infection source identification, care transitions, discharge planning, podiatry scheduling, wound care, and resident supervision.

To listen to the podcast on the OIG's April 2019 activity highlights, go to www.va.gov/oig/podcasts.